

6864

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b x near - Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Co. Hospital				/d. STREET ADDRESS RFD * Skinner's Neck		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James H. Boulter				4. DATE OF DEATH Month Day Year June 23, 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/1/79	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman (fishinf & etc.)				10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Boulter				14. MOTHER'S MAIDEN NAME Elizabeth Ashley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. John Boulter - Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease 422.1 DUE TO with Advanced Congested Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/21 , 19 59 , to 6/23 , 19 59 , that I last saw the deceased alive on 6/23 , 19 59 , and that death occurred at 8 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 6/25/59 ACTUAL SIGNATURE Robert W. Farr M.D. PHYSICIAN'S NAME (Type) Robert W. Farr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/59		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) nr. Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR DATE JUN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital, and the attending physician and coroner must be filled in by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6865 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06856

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Annes	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Annes		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Henry Cain		4. DATE OF DEATH June 24 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1932 27 yrs.
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Cain		14. MOTHER'S MAIDEN NAME Erma Mae Stubbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-36-1341	
17. INFORMANT Hospital records, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable hepatic toxemia and bile peritonitis 2 days 835x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of liver (extensive), Avulsion of common bile duct from duodenum, & laceration of splenic pedicle (c) 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> Was thrown from tractor, and run over by disk harrow being pulled by the tractor.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year June 22, 59 Hour a. m. 1:30		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
20e. (City or town) Ingle side		20f. (County) Queen Annes	
20g. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/59	
22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS J. E. Boulaes, Greensboro, Md.		24a. REC'D BY REGISTRAR June 29 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

AGE

SEX

DATE

PLACE OF DEATH

TIME

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

NAME

AGE

PLACE OF BIRTH

Probable hepatic toxemia and disseminated intravascular coagulation

Diagnosis of liver toxemia, infection of systemic nature

3 days

10:30 AM

Was this an acute case, and run over by dark matter?

Indicate even under

11:30 AM June 22, 1933

12:30 AM June 22, 1933

1:30 AM June 22, 1933

2:30 AM June 22, 1933

6868

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE md b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First MINNIE Middle T Last CARROLL		4. DATE OF DEATH Month JUNE Day 25 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 24, 1884 9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME E. M. Taylor	
14. MOTHER'S MAIDEN NAME Mrs. Sawyer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215-09-6944		17. INFORMANT George A. Taylor Rock Hall Address	
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Liver DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Breast DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/2/59 , 19____, to 6/25/59 , 19____, that I last saw the deceased alive on 6/16/59 , 19____, and that death occurred at 5:00 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE William M. Gatewood M.D.		ADDRESS (Street, city or town, state) Rock Hall, md DATE SIGNED 6/26/59	
PHYSICIAN'S NAME (Type) WILLIAM GATEWOOD		Rock Hall	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 6-27-59	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel	22d. LOCATION (City, town, or county) (State) Rock Hall md
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lowe ADDRESS Church Hill md		24a. REC'D BY REGISTRAR JUL 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1928

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
DATE OF BIRTH		PLACE OF BIRTH	
PARENTS		SIBLINGS	
GRANDPARENTS		OTHER RELATIVES	
DEATH CERTIFICATE		BURIAL CERTIFICATE	
SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF BURIAL CERTIFICATE	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF SIGNATURE		NAME OF SIGNATURE	
TITLE OF SIGNATURE		TITLE OF SIGNATURE	
OFFICE OF SIGNATURE		OFFICE OF SIGNATURE	
STATE OF SIGNATURE		STATE OF SIGNATURE	
COUNTRY OF SIGNATURE		COUNTRY OF SIGNATURE	
WITNESSES		WITNESSES	
DATE OF WITNESSES		DATE OF WITNESSES	
PLACE OF WITNESSES		PLACE OF WITNESSES	
NAME OF WITNESSES		NAME OF WITNESSES	
TITLE OF WITNESSES		TITLE OF WITNESSES	
OFFICE OF WITNESSES		OFFICE OF WITNESSES	
STATE OF WITNESSES		STATE OF WITNESSES	
COUNTRY OF WITNESSES		COUNTRY OF WITNESSES	

ORIGINAL RECORD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6869

CERTIFICATE OF DEATH

06858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Worton		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton RFD	
f. STREET ADDRESS RFD		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oliver Middle Hyhson Last Hyhson		4. DATE OF DEATH Month June Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U SA	
13. FATHER'S NAME Elmore Hynson		14. MOTHER'S MAIDEN NAME Amanda Ringgold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-16-5166	
17. INFORMANT Anna Hynson		Address Worton, RFD Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 544.2 Acute Indigestion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1918 , to June 9, 1959 , that I last saw the deceased alive on June 9, 1959 , and that death occurred at Rock Hall, Maryland , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Kester		DATE SIGNED 6/10/59	
PHYSICIAN'S NAME (Type) Eugene Kester		ADDRESS (Street, city or town, state) Rock Hall, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 13 1959	
22c. NAME OF CEMETERY OR CREMATORY Fountain Cem. (Bigwoods)		22d. LOCATION (City, town, or county) (State) Worton Md. RFD	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		24a. REC'D BY REGISTRAR DATE JUN 12 '59	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Carlton S. Hanna	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6870 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06859

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Rock Hall c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Ad. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 02X-2 d. STREET ADDRESS RFD 7 Box 377 D, Pasadena, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First JAMES Middle REUBEN Last KARNS				4. DATE Found Month June Day 22 Year 1959 OF DEATH											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/26/25		9. AGE (In years last birthday) 34 yrs. 10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Wright				10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.				11. BIRTHPLACE (State or foreign country) Cumberland, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Terrance Karns						14. MOTHER'S MAIDEN NAME Violet Widows									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII				16. SOCIAL SECURITY NO. 220-16-6688				17. INFORMANT Address Violet Karns, Cumberland, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 												INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of boat.											
20c. TIME OF INJURY Month, Day, Year Hour XXX 6/17 1959 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bay		20f. (City or town) Rock Hall		(County) Kent		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Charles S. Petty</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 6/23/59			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/26/59		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery				22d. LOCATION (City, town, or county) (State) Cumberland, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc., Cumberland, Maryland						24a. REC'D BY REGISTRAR DATE JUN 29 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>							

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

NAME OF DECEASED WILL WRIGHT		SEX Male	
AGE 37		DATE OF BIRTH 1900	
OCCUPATION Bath Steel Co., Cumberland, Maryland U. S. A.		PLACE OF BIRTH Bath Steel Co., Cumberland, Maryland U. S. A.	
MARITAL STATUS Married		NAME OF SPOUSE Violet Karna	
CAUSE OF DEATH Yes		MANNER OF DEATH Will	
PLACE OF DEATH Bath Steel Co., Cumberland, Maryland		DATE OF DEATH 1937	
SIGNATURE OF MEDICAL EXAMINER [Signature]		SIGNATURE OF WITNESS [Signature]	
NAME OF FUNERAL HOME [Name]		ADDRESS OF FUNERAL HOME [Address]	
NAME OF NEXT OF KIN [Name]		ADDRESS OF NEXT OF KIN [Address]	
NAME OF BURIAL PLACE [Name]		ADDRESS OF BURIAL PLACE [Address]	

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CERTIFICATE OF DEATH

Reg. Dist. No.

6866

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 532 Cannon St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH E. Middle LONG Last				4. DATE OF DEATH Month June Day 17 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29 1892		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Fairlee Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Long				14. MOTHER'S MAIDEN NAME Sarah Hopkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ----		16. SOCIAL SECURITY NO. 201-03-8923		17. INFORMANT Mrs. Eva Long Address 532 Cannon St. Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to June 17 1959 , that I last saw the deceased alive on June 17 1959 , and that death occurred at 11 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 6/18/59 ACTUAL SIGNATURE Robert W. Farr M.D. PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/59		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR DATE JUN 23 59		24b. REGISTRAR'S SIGNATURE Arthur S. Frazee	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

10-20-00

1. NAME OF DECEASED Robert A. Smith		2. PLACE OF BIRTH St. Louis, Mo.	
3. SEX Male		4. AGE 35	
5. DATE OF DEATH June 17, 1900		6. PLACE OF DEATH St. Louis, Mo.	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural	
9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		10. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
11. COUNTY St. Louis		12. STATE Mo.	
13. CITY St. Louis		14. STREET 1234	
15. DISTRICT 1		16. WARD 1	
17. BLOCK 1		18. LOT 1	
19. HOUSE NO. 1234		20. APARTMENT NO. 1	
21. BUILDING NO. 1234		22. TRACT NO. 1234	
23. SECTION NO. 1234		24. TOWNSHIP NO. 1234	
25. RANGE NO. 1234		26. MERIDIAN 1234	
27. CORNER NO. 1234		28. BEARING 1234	
29. DISTANCE 1234		30. AREA 1234	
31. VOLUME 1234		32. PAGE 1234	
33. BOOK NO. 1234		34. PAGE NO. 1234	
35. COUNTY NO. 1234		36. STATE NO. 1234	
37. CITY NO. 1234		38. STREET NO. 1234	
39. DISTRICT NO. 1234		40. WARD NO. 1234	
41. BLOCK NO. 1234		42. LOT NO. 1234	
43. HOUSE NO. 1234		44. APARTMENT NO. 1234	
45. BUILDING NO. 1234		46. TRACT NO. 1234	
47. SECTION NO. 1234		48. TOWNSHIP NO. 1234	
49. RANGE NO. 1234		50. MERIDIAN 1234	
51. CORNER NO. 1234		52. BEARING 1234	
53. DISTANCE 1234		54. AREA 1234	
55. VOLUME 1234		56. PAGE 1234	
57. BOOK NO. 1234		58. PAGE NO. 1234	
59. COUNTY NO. 1234		60. STATE NO. 1234	
61. CITY NO. 1234		62. STREET NO. 1234	
63. DISTRICT NO. 1234		64. WARD NO. 1234	
65. BLOCK NO. 1234		66. LOT NO. 1234	
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69. BUILDING NO. 1234		70. TRACT NO. 1234	
71. SECTION NO. 1234		72. TOWNSHIP NO. 1234	
73. RANGE NO. 1234		74. MERIDIAN 1234	
75. CORNER NO. 1234		76. BEARING 1234	
77. DISTANCE 1234		78. AREA 1234	
79. VOLUME 1234		80. PAGE 1234	
81. BOOK NO. 1234		82. PAGE NO. 1234	
83. COUNTY NO. 1234		84. STATE NO. 1234	
85. CITY NO. 1234		86. STREET NO. 1234	
87. DISTRICT NO. 1234		88. WARD NO. 1234	
89. BLOCK NO. 1234		90. LOT NO. 1234	
91. HOUSE NO. 1234		92. APARTMENT NO. 1234	
93. BUILDING NO. 1234		94. TRACT NO. 1234	
95. SECTION NO. 1234		96. TOWNSHIP NO. 1234	
97. RANGE NO. 1234		98. MERIDIAN 1234	
99. CORNER NO. 1234		100. BEARING 1234	

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RECEIVED
BALTIMORE
JUN 17 1900
STATE DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06861

6871

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ethel</u> First <u>M.</u> Middle <u>Nitsch</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>19 59</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 19-1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>27</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Katzenberger</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Chalmers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Norbert Nitsch Jr. Rock Hall, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema & Uremia</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetic Arteriosclerotic Cardio-Renal Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic Gangrene Rt. Foot</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 10, 1959</u> to <u>June 27, 1959</u> , that I last saw the deceased alive on <u>June 27, 1959</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Keefe Jr.</u>		DATE SIGNED <u>Chestertown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Arthur T. Keefe</u>		<u>Chestertown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 30</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar D. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

10-01

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. TIME OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>		<p>9. MEDICAL HISTORY [Faint text]</p>	
<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>14. SIGNATURE OF CLERK [Faint text]</p>		<p>15. SIGNATURE OF JURY [Faint text]</p>	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE 18

6867
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 11 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hartly 46x-3				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Pratt Last Waddell				4. DATE OF DEATH Month June Day 1 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/88	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. H. Waddell				14. MOTHER'S MAIDEN NAME Annie McIlhinney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 195-05-8298		17. INFORMANT Address Mrs. Margaret Waddell Hartly, Dela.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Failure 456X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Renal insufficiency DUE TO (c) Pericarditis No Dosa						INTERVAL BETWEEN ONSET AND DEATH 2 Days 2 months 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dishman for 17 Days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/21 , 19 59 , to 6/1 , 19 59 , that I last saw the deceased alive on 6/1 , 19 59 , and that death occurred at 4:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown DATE SIGNED 6/1/59							
ACTUAL SIGNATURE Thomas J. Solon				M.D. Chestertown			
PHYSICIAN'S NAME (Type) Thomas J. Solon				Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/59		22c. NAME OF CEMETERY OR CREMATORY Lawncroft Cem.		22d. LOCATION (City, town, or county) (State) Linwood, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wilks Wilks				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JUN 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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